compbenefits
vision
dental

Employee/Retiree Enrollment Form

RETURN THIS FORM IF YOU ARE A NEW ENROLLEE.

Effective January 1, 2008, I have enrolled for one of the dental plans offered under the Shelby County Government Flexible Benefits Plan.

I authorize Shelby County Government to deduct an amount equal to the employee cost of the plan from my wages each pay period on a pre-tax basis. My W-2 statement will show my wages after this redirection. I understand that my enrollment for dental insurance and related payroll redirection is IRREVOCABLE and may not be changed until the next January 1, except in case of a change in family status, as provided under Article 3 of the Flexible Benefit Plan. If you are not enrolled in Shelby County Government Flexible Plan this coverage will be on an after-tax basis.

Please Select One:

Option I	Option II	Option III	Option IV
☐ Basic DHMO - Prestige 45	☐ Enhanced DHMO - Prestige 15	☐ Basic PPO - Elite Preferred 520	☐ Enhanced PPO - Elite Preferred 510

Please Select One:

☐ Employee ☐ Employee + One ☐ Family

Amount deducted Active Employee (per pay period) /Head Start (per pay period) /Retiree (per month): $ _____

EMPLOYEE INFORMATION (Please Print)

Social Security No.	**Dental Facility #:** (Options I [PST45] and II [PST15] Only)		
Last Name	First	MI	Date of Birth / /
Home Address	Home Phone ( )	Business Phone ( )	
City State		Zip Code	Sex ☐ **M** ☐ **F**
Employer's Name: **Shelby County Government**	Occupation:		
Are you now performing all duties of your regular occupation on a full-time basis (20 hours per week or more)? ☐ **YES** ☐ **NO**	Full-Time Date of Hire:		

If covering your dependents, please complete the following:

(Please note it is the responsibility of the employee to inform the Shelby County Employee Benefits Office if a dependent has reached the maximum age limit or if their status has changed.)

First	Middle	Last (if Different)	**Dental Facility #** (Options I [PST45] and II [PST15] Only)	Sex	**Birthdate**
Spouse				☐ M ☐ F	/ /
Child				☐ M ☐ F	/ /
Child				☐ M ☐ F	/ /
Child				☐ M ☐ F	/ /
Child				☐ M ☐ F	/ /

AGREEMENT AND AUTHORIZATION

All the information I have provided on this enrollment form is true and complete to the best of my knowledge and belief. I agree that the insurance coverage is not in force until it is approved by UniLife Insurance Company or the applicable subsidiary of CompBenefits Corporation for DHMO Dental Care.

If enrolling for the DHMO Dental Care plan, I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage. I authorize my employer to make any necessary payroll deductions.

The following is required in certain states: Any person who knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.

Signature: _____ Date: _____

Office Use Only:

Employee (EIN) Number: _____

Effective Date _____

Entered by _____

Comments _____

_____